



Connecticut Elder Action Network (CEAN)

A dynamic network of leaders advancing responsible public policy

Legislative Summary

November 2003

Executive Committee

CT Commission on Aging, Chair

AARP – CT

Center for Medicare Advocacy Inc.

CT Association of Area Agencies on Aging

CT Coalition on Aging

CT Community Care, Inc.

CT Council of Senior Citizens, Inc.

CT Association of Municipal Agents for the Elderly

CT Association of Senior Center Personnel

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Brief Background

Connecticut Elder Action Network

In response to requests from legislators that older adults and their advocates do their best to speak with a common voice, stakeholders throughout Connecticut came together to form a working advocacy group whose main goal was to develop and pursue a well-supported short list of legislative priorities. This effort, which has become known as the Connecticut Elder Action Network (CEAN), has involved a dynamic group of leaders working together to advance responsible public policy for elders. Its Executive Committee members include: the Connecticut Commission on Aging, AARP-CT, the Center for Medicare Advocacy, Inc., the Connecticut Association of Area Agencies on Aging, the Connecticut Coalition on Aging, the Connecticut Council of Senior Citizens, Inc., the Connecticut Association of Municipal Agents for the Elderly, the Connecticut Association of Senior Center Personnel, and Connecticut Community Care, Inc.

Entering the 2003 session, CEAN developed and promoted the following priority areas:

- **Connecticut Pharmaceutical Assistance Contract for the Elderly and Disabled (ConnPACE)**
 - maintenance of adequate overall program funding
 - support for the 1115 waiver application that seeks to expand income eligibility limits to 300% of the poverty level
 - protection for existing dosage amounts per fill and the annual cost-of-living increases
- **Elderly Nutrition**
 - maintenance and expansion of state support for home-delivered and congregate meals
- **Connecticut Commission on Aging**
 - re-location of the independent Commission to the legislative branch of government for administrative purposes only
 - preservation of its voting membership of exclusively citizen volunteers
 - continued representation of key State Departments
 - maintenance of the existing statutory mandate that the Commission be staffed, at minimum, by an Executive Director

Primary rationales for selection of these three areas were:

- 1) that pharmaceutical drugs, costs for which are prohibitively expensive for those elders without a source of financial assistance, are a critical element of community-based long-term care;

- 2) that meals represent a vital source of balanced nutrition, a social connection with the delivery person, and an essential element of preventative health; and
- 3) that the Commission is the independent voice within state government for Connecticut's 600,000 plus population of older adults, and requires autonomy and adequate staffing to perform its statutory charge.

Results of the 2003 Session

In reviewing the results of the session, four main strains emerge that implicate long-term care services for older adults. These are:

- 1) the State's demonstrated commitment to maintenance and expansion of affordable home and community-based services for low-income elders;
- 2) the State's efforts to require seniors to pay for their own long-term care expenses, as opposed to relying on the State as the primary payor;
- 3) the State's interest in controlling prescription drug costs through such devices as application for Medicaid reimbursement for costs under the ConnPACE program, increased cost-sharing by recipients of assistance, stricter eligibility guidelines, prior authorization, and a preferred drug list; and
- 4) the State's efforts to protect vulnerable elders from harm and exploitation, whether they reside in nursing facilities or the community.

This summary offers a capsule of each of these major themes by acknowledging new initiatives that became law, as well as noting where raised bills failed somewhere along the process and why.

I. Commitment to Affordable Home and Community-Based Services

Over the past five years, the Administration and the Legislature have made steady progress in enhancing Connecticut's commitment to affordable home and community-based services. Examples of this commitment include:

- 1) expansion of the service array of the Connecticut Home Care Program for Elders (CHCPE) to include a pilot that permits 50 individuals statewide to hire, train and flexibly manage a personal care assistant;
- 2) creation of alternate methods by which CHCPE services can be received, including permitting residents of state-funded congregate buildings to receive their program service through an on-site assisted living agency; and a pilot that permits a certain number of residents of managed residential care buildings who have exhausted their financial resources to have their services (but not room and board) paid through the program; and
- 3) authorization for free-standing, new construction assisted living buildings (in process).

Most notable in the 2003 Session, FY'2004-5 funding for the Connecticut Home Care Program for Elders will continue to ensure rolling access to all eligible applicants. Further, the Legislature has recognized that an essential element of ensuring access to needed services is a healthy, financially-stable network of home care providers. Another result of the session, therefore, was approval of a 2% rate increase for providers which will partially offset increases in their costs of

doing business. Unfortunately, this rate of increase continues to fall far short of the level supported by the Connecticut Home Care Association.

Further, the Legislature recognized the benefit of a program that is effectively serving families caring for an individual with dementia by restoring the Statewide Respite Program to its full FY'03 funding level.

No Action/Not Enacted

Home and Community-Based Care Eligibility/Coverage

Despite the fact that they were not signed into law, two other bills are also notable in proposing significant expansions to the asset limits for the State-funded levels of the CHCPE, and that personal care assistants become a permanent service of the program. Although well-received, these were casualties of budget constraints.

Proposals to 1) reinstate medical services (e.g. vision care, podiatry, home health care and therapies) previously available under State Administered General Assistance (SAGA) and Medicaid; 2) require insurance coverage for talking prescription containers and hearing aids; and 3) amend eligibility requirements for medical assistance by increasing the unearned income disregard by the average % increase in the CPI over the previous year were not acted on before end of session. Bills that proposed to allow a cost-of-living increase in the income limits used to determine Medicaid eligibility and to directly reimburse managed residential communities for providing assisted living services to residents who meet Medicaid eligibility requirements died in committee.

Capacity of the Home Care Network

Bills that proposed to address nursing and CNA shortages through schooling initiatives, tuition forgiveness and licensing of nurses from other states and territories died in committee.

II. Efforts to Require Elders to Pay for Their Long-Term Care

Through position statements of the Administration, as well as the Governor's budget proposals, state policy makers have outlined strategies designed to require elders to bear more of their own long-term care expenses.

Partnership Program

The primary vehicle through which this is being pursued is through promotion of the State's Partnership program, a regulated array of long-term care insurance policies. Given the Administration's concession and concern, however, that this strategy will not immediately shift the "culture" of consumer's expectations concerning payment for long-term care, the State has also brought recommendations to the Legislature concerning rule changes that are designed to limit access to the Medicaid program.

Waiver Request

To this end, in 2001, the Department of Social Services submitted a waiver request to the Centers for Medicare and Medicaid Services seeking a rule change for the Medicaid program

that is designed to discourage older adults from giving away resources, however innocently, that could otherwise be spent on their long-term care needs.

Given the current method (established by federal Medicaid law) through which eligibility for the program is determined, an individual could have made a transfer of funds, whether innocent or deliberate, to an adult child within the three-year period prior to applying and still qualify for support. This is because the eligibility determination evaluates how much was transferred, and divides that amount by the average monthly cost of nursing home care. The resulting number is the number of months **from the date on which the transfer occurred** that the individual is judged ineligible for Medicaid. In many cases, this ineligibility or “penalty” period has already run by the time that someone needs support from the State.

In response to this, the State’s request seeks to establish that a penalty period for transfer of assets for less than fair market value begin in the month in which the applicant is otherwise eligible for Medicaid coverage of services (as opposed to the date on which the transfer occurred). The waiver request further proposes to change the look-back period for real estate transfers from 3 to 5 years. This request is still pending with CMS, and it is difficult to know when or if it will be implemented.

Transferee Liability

Section 62 of P.A. 03-3 further seeks to deter individuals from gifting away their resources by imposing transferee liability (an obligation to reimburse the State) where adult children or others have received assets from individuals applying for Medicaid. There remain questions about the effective date of this legislation, which appears to be linked to approval of the transfer of assets waiver.

“Income-First”

Finally, **Section 63 of P.A. 03-3** adopts an “income first” rule where additional funds are needed to make up the “community spouse minimum monthly needs allowance”. This occurs where one partner in a married couple needs nursing home care and is seeking Medicaid support for those services. At the time of application for Medicaid, the State evaluates the couple’s finances, and using a method established by federal law, divides up their assets such that the nursing home resident applies his or her half to the cost of care, and the spouse still in the community retains the other half for their own use. The “income first” rule removes an existing option that in certain situations permits more than one-half of the couple’s assets to be given to the “community spouse”. Until passage of this law, this was permitted where a “community spouse” did not have sufficient income of his or her own on which to live, and where the additional assets would generate additional income to meet those needs. Removing this option is an effort on part of the State to preserve the full amount of assets with which the spouse in the nursing home can pay for his or her care before qualifying for Medicaid assistance.

Response of the Advocacy Community

In response to all the above, many in the advocacy community have argued that this entire approach sets a punitive tone and comes associated with serious risks of harm. Rather than a “carrot” approach, such as providing tax incentives for purchase of long-term care insurance and/or caregiving, the State adopts a “stick” strategy that seeks to characterize older adults as willfully defrauding the Medicaid program. Further, though certain language has been added in subsequent legislation to provide safeguards for individuals with dementia, and those who have

been coerced, the vast majority of unwitting older adults who may make transfers are not helped by these provisions. Finally, despite the addition of certain protections for nursing homes in the event a resident is left without a source of payment, there remain no protections for elders living in the community who are found ineligible for Medicaid support. In summary, advocates have responded:

- 1) that the literature (e.g. national AARP consumer survey, 2000) shows that consumers **do not** have a good grasp of the intricate rules of the Medicare and Medicaid programs, rendering implausible claims that they purposefully plan to make end runs around Medicaid rules;
- 2) that this policy does not adequately acknowledge the magnitude and dollar value of informal, family caregiving, which represents an incredible, substantiated deferral of use of public funds (a ready example here is in the Statewide Respite Program, which very typically sees families coming in at a late stage of the loved one's disease, never previously having utilized the formal long-term care system);
- 3) that reliance on long-term care insurance as a primary replacement for foregone State support is overemphasized in that such insurance is very costly (e.g. the Connecticut Partnership cites sample cost ranges for various amounts of coverage for policies purchased at age 65 that start at \$1,200 and trend up to \$3,800 or more per year) and inaccessible to individuals with chronic conditions by reason of strict medical underwriting rules; and
- 4) that the transfer of assets rule change, if approved,
 - a) sets an unachievable standard of requiring individuals to show "clear and convincing contrary evidence" that a transfer was not made to qualify for Medicaid; and
 - b) runs a serious risk of leaving individuals in the community foreclosed from care through the Connecticut Home Care Program for Elders just at the time they need it (e.g. the date of application), without private resources or other recourse to pay for care that may prevent or forestall much more costly hospitalization or nursing facility care.

No Action/Not Enacted

Proposals to 1) create a deduction for long-term care expenses relating to care of an older adult by an immediate relative in the relative's home; 2) to create a deduction for certain nursing home expenses; and 3) to create a property tax exemption for senior housing and assisted living services to encourage purchase of long-term care insurance died in committee.

Further, a proposal to prohibit Medicare supplement insurers from raising Medigap policy rates for six months from the date on which a policy is released was not acted on before the end of the session. Bills that proposed to require Medicare supplement insurers to offer their products to all Medicare recipients died in committee.

III. Efforts to Control Pharmacy Costs

The State has approached the serious problem of escalating pharmacy costs through five strategies: application for Medicaid reimbursement for costs under the ConnPACE program; increased cost-sharing by recipients of assistance, stricter eligibility guidelines, prior authorization, and a preferred drug list. Frustratingly, these approaches have almost exclusively

impacted consumers, through restriction of access to help with the cost of drugs, contraction of what is covered by ConnPACE and a significant increase in the co-payment a senior is asked to make for each fill. While there have been certain efforts on the part of the State to pursue “supplemental” rebates from pharmaceutical companies, the bulk of the efforts to contain costs have not impacted the prices at which the State is procuring drugs through its pharmacy programs.

Application for Medicaid Reimbursement of ConnPACE Costs

Faced with burgeoning costs, one strategy that the State has used is to seek federal cost-sharing with the costs of the Connecticut Pharmaceutical Assistance Contract for the Elderly and the Disabled (ConnPACE). At a joint hearing on February, 2002 the Appropriations, Human Services and Public Health Committees voted to approve DSS’s proposal to seek a federal Medicaid waiver to expand the ConnPACE program to 300% of the Federal Poverty Level (\$25,770 for an individual, \$34,830 for a couple). This request seeks to expand the scope of the program, but would also prohibit individuals from applying the share of their prescription drugs that is paid by ConnPACE to their Medicaid spend-down requirement. The waiver request was forwarded to the Centers for Medicare and Medicaid Services, and is still pending review. Approval would mean expansion of the income limits through sharing of costs between the federal government and the State, but is by no means assured as a number of prescription drug waivers at significantly lower levels of coverage are also being reviewed at this time.

Cost-Sharing

The State has also shifted more out-of-pocket costs to participants of the programs. **Section 14 of P.A. 03-2**, which was effective upon passage on February 28, 2003 authorized:

- 1) raising co-payments from \$12 to **\$16.25** per prescription for single participants with incomes less than \$20,300 and married participants with incomes less than \$27,500;
- 2) if the waiver is approved, raising co-payments to **\$20** for single participants with incomes greater than or equal to \$20,300 and married participants with incomes greater than or equal to \$27,500; and
- 3) increasing the annual registration fee from \$25 to **\$30**.

Further, **Section 43 of P.A. 03-3** increases the co-payment that SAGA recipients are required to pay for prescription drugs from \$1 to \$1.50 per prescription; this at a time when their monthly benefits have just been reduced.

Stricter Eligibility Guidelines

Two sections of **P.A. 03-3** affect the terms of participation in the ConnPACE:

Section 58, effective October 1, 2003, limits eligibility for the ConnPACE program to those individuals whose available assets are below \$100,000, and those couples whose available assets are below \$125,000. Available assets are defined as those considered for eligibility for the Home Care Program for Elders (for example, an individual’s home is not considered an available asset).

Section 59 imposes recovery provisions on the estates of ConnPACE recipients who die on or after September 1, 2003. Claims will apply to benefits received on or after July 1, 2003.

Prior Authorization

Another method that has been used is to limit access to brand-name drugs through publicly-funded programs. Approved by the Legislature on May 24, 2002, Connecticut's "prior authorization" plan requires doctors to seek approval from a DSS contractor for all 1) brand-name drugs with generic equivalents; 2) prescriptions for drugs that cost more than \$500 for a 30-day supply; and 3) early refills where less than 75% of the original prescription has been used up. **Section 52 of P.A. 03-2 describes the particulars of the plan, which was implemented on July 16th, 2003.**

Three sections of **P.A. 03-3** further clarify the State's intent with respect to prior authorization:

Section 69 requires DSS to seek a waiver of federal Medicaid requirements such that pharmacists would be authorized to refuse to fill prescriptions for Medicaid recipients where there is "documented and continuous failure to make required co-pays, notwithstanding having the financial ability to do so". "Continuous failure" is defined as 1) failure to make a co-payment within 6 months of receiving the drug; or 2) failure to make 6 or more co-payments for prescriptions that are filled in any 6-month period. This section does not apply to psychotropic drugs.

Section 82 requires pharmacists to fill prescriptions for Medicaid, ConnPACE and SAGA recipients using the most cost-effective dosage feasible that is consistent with the prescription. **Section 84**, however, indicates that where a brand-name drug is less expensive than a generic (by reason of supplemental rebate on the brand-name), the pharmacist must fill with the brand-name drug.

Preferred Drug List

Finally, Connecticut has taken the initial steps toward limiting the roster of drugs to which program participants may have access. **Section 83** invokes the previously enacted requirement that DSS adopt a preferred drug list for the Medicaid and ConnPACE programs for three classes of drugs (proton pump inhibitors and two additional classes to be identified by DSS). This list is likely to expand in the future.

No Action/Not Enacted

Bills to 1) create an Affordable Prescription Drug Board and to permit DSS to negotiate supplemental rebates; 2) authorize participation in the National Legislative Association on Prescription Drug Prices; and 3) permit married couples to apply as individuals, require DSS to implement the expanded income eligibility limits sought in the Medicaid waiver application, and designate maximum permitted quantity per prescription were not acted on before the end of the session. Bills that proposed to enact a spend-down provision and to establish a Part B died in committee. Finally, an effort on the part of the Administration to limit supply of drugs received in each fill through the ConnPACE program was not included as part of the final Department of Social Services implementer bill.

IV. Enhancement of Protections for Vulnerable Elders

A final area of concern to legislators was the need for additional protections for frail elders living in nursing facilities and the community. Three major strategies emerged here: first, regulatory measures designed to promote quality care in the nursing home setting; second, new physical plant requirements for nursing facilities; and third, enhanced requirements concerning reporting of elder abuse.

Toward the goal of promoting quality care in nursing facilities, three bills were signed into law:

P.A. 03-92 addressed the long-time complaint that nursing facilities can too readily anticipate when inspectors from the Department of Public Health will be making their annual visits by requiring that nursing home inspections be more random and unannounced.

Further, **Section 20 of P.A. 03-3** increased from 20 to 40 the number of hours of continuing education that are required for nursing home administrators.

Finally, **Section 74 of P.A. 03-3** adds an exception to the wait list law that permits nursing facilities to immediately admit an applicant who is transferring from a nursing facility that is closing. This will help to prevent the situation in which older adults are left with no geographically immediate alternative placement in the face of the financial failure of a facility.

Physical plant considerations were also taken seriously during the session.

Following the devastating fire in Hartford that left many residents of a nursing facility dead, **Section 92 of P.A. 03-3** requires that nursing facilities install automatic fire extinguishing systems.

In light of the effect that extreme temperatures have on frail individuals and those with breathing problems, **P.A. 03-272** further requires that nursing facility rooms have adequate cooling devices.

Finally, a need for strengthened elder abuse reporting and whistleblower protections was also identified.

P.A. 03-267 requires prompt reporting of suspected abuse of elderly persons in the community and in nursing facilities, and protects elders and mandatory reporters from retaliation for reporting such abuse.

No Action/Not Enacted

A proposal to require criminal history checks of nursing home employees was again not acted on before the end of the session. This initiative, re-introduced session after session, has continued to raise concern among advocates for low-income workers. Their argument is that the background checks may pick up offenses so remote in time or unrelated in nature to the work that will be performed that the result may unfairly foreclose an applicant from employment.

Further, proposals to 1) require screening on admission of individuals who may pose a threat to residents; and 2) require registration and licensing of assisted living facilities either died in committee or were not acted upon before the end of the session.

Finally, a proposal to encourage placement of conserved individuals in settings that best accommodate their medical and social needs failed in committee.

V. Other Areas

Nutrition

The bulk of state support for home-delivered and congregate meal programs derives from the Elderly Services line of the Department of Social Services' budget. While a break-out of these figures has not yet been released, the Agencies on Aging have been notified that the nutrition program has been provided additional funding for the FY'04 year. Unfortunately, this line remains vulnerable to rescission and therefore should must be monitored throughout the year.

Commission on Aging

Despite broad support for shifting the Commission on Aging to the legislature for administrative purposes only, no action was taken on the bill to do so prior to the end of the session.

Transportation

In its *Preliminary Long-Term Care Plan* (2000), Connecticut's Long-Term Care Committee recognized that expanded transportation services are integral supports that allow older adults and younger disabled individuals to live successfully in the community. In its *Elderly Transportation Services* report [December 1998], the Legislative Program Review and Investigation Committee (LPRI) concluded that:

- *no state agency has responsibility for program oversight because there is no state mandate for dial-a-ride programs for the elderly;*
- *no single funding source exists, instead funding is a patchwork of federal, state and local monies; and*
- *multiple delivery models exist, making identification of programs problematic.*

Despite the recommendations presented in this report, the Legislature has subsequently been challenged by limited funding and structural issues (e.g. lack of regionalism in operation of transit districts) in achieving coordination and increased funding for paratransit serving older riders. No bills concerning Dial-a-Ride or other elderly services transit passed during the 2003 session.

Housing

Similar to the attention that has been drawn to gaps and constraints in the transportation network, advocates have continued to outline the inadequacy of affordable, accessible housing. With the exception of the initiative concerning development of free-standing, affordable assisted living described above, no bills concerning expansion of housing opportunities were raised in the 2003 session.

Electric Deregulation

Public Act 03-135 revised the electric restructuring law, among other provisions, by increasing the maximum rate that consumers can be charged for service. Notable to older adults, as highlighted by AARP advocacy, is that since passage of the Act, CL&P has filed an application with the Connecticut Department of Public Utility Control (DPUC) attempting to increase electric rates by 11%, a full 7% greater than was anticipated by the General Assembly and a higher level than appears to be permitted by the provisions of the law, which caps rates through 2006 at 1996 levels. This remains an active advocacy issue.

VI. Conclusion

The 2003 Legislative Session in Connecticut was enormously challenging to all of its participants: legislators, advocates and citizens. Structural deficit, significant growth rates in the Medicaid and pharmacy assistance programs, and increasing incidence of need defied simple budget resolution. Further, calls for expansion of existing programs were next to irreconcilable with the hard reality of across-the-board cuts. It is a lean time in Connecticut. It is a time for shared burdens. But it is also a time at which Connecticut is on the cusp of significant new demand for publicly-supported programs and benefits to serve the needs of its older adults, and the Administration and legislators have begun the process of grappling with strategies to balance these diverse interests.

Despite significant commitment on the part of the State to the concept and practice of home and community-based care, the level of public resources devoted to institutional care remains disproportionate to that expended through home care supports. This issue clearly warrants additional efforts to work through the complex shift of funds, personnel and infrastructure that is involved. Further, the trend toward emphasizing personal responsibility in payment for long-term care should be tempered by tax and workplace incentives to do so, and policy makers must be vigilant in preserving access to support for those in legitimate need. Finally, lawmakers should consider the investment value of establishing additional safeguards for vulnerable elders that will safeguard them from preventable harm.

For more information on becoming involved with CEAN, please email:

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